II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	PPO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$500	$1,000
Family	$1,000	$2,000
Coinsurance After Deductible	30%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum		
Individual	$6,350	Not Covered
Family	$12,700	Not Covered
Physician Office Visits		
Primary Care Physician	$15 copay	50% coinsurance after deductible
Specialist (includes cardiologists, psychiatrists, etc.)	$25 copay	50% coinsurance after deductible
Preventative Care (Limited 1 per calendar year. Includes physical exam, mammography, etc.)		
Well Adult Care	No Charge	50% coinsurance after deductible
Well Child (Includes immunizations)	No Charge	50% coinsurance after deductible
Well Woman Care	No Charge	50% coinsurance after deductible
Allergy Tests and Treatment	30% coinsurance after deductible	50% coinsurance after deductible
Infertility Treatment	Not Covered	Not Covered

SUMMARY OF BENEFITS	PPO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Maternity Care Prenatal and Postnatal Care	30% coinsurance after deductible	50% coinsurance after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient (excludes Skilled Nursing Facility, Hospice Care and Home Health Care)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient (excludes Private Duty Nursing, Home Health Care, and Hospice)	30% coinsurance after deductible	50% coinsurance after deductible
Ambulance	30% coinsurance after deductible	30% coinsurance after deductible
Emergency Services Hospital ER	$100 copayment (Waived if admitted)	$100 copayment (Waived if admitted)
Urgent Care Center	$15 copay	$15 copay
Outpatient Laboratory Testing and X-Ray	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery	30% coinsurance after deductible	50% coinsurance after deductible
Human Organ Transplant	30% coinsurance after deductible	50% coinsurance after deductible
Mental and Nervous Expense Inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient	$25 copayment	50% coinsurance after deductible

SUMMARY OF BENEFITS	PPO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Alcohol & Substance Abuse		
Inpatient	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient	$25 copayment	50% coinsurance after deductible
Durable Medical Equipment and Prosthetics (Total rental not to exceed purchase price.)	30% coinsurance after deductible	50% coinsurance after deductible
External Prosthetic Devices	30% coinsurance, after deductible	50% coinsurance, after deductible
-Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia- male pattern baldness)	30% coinsurance, after deductible, and any amount over $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum
Rehabilitation Services		
Physical, (Up to 30 visits per calendar year. Excludes Chiropractic Services)	$25 copay	50% coinsurance after deductible
Speech and Occupational Therapy (Up to 30 visits per calendar year)	$25 copay	50% coinsurance after deductible
Cardiac Rehabilitation Therapy	30% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care	Not Covered	Not Covered

PRESCRIPTION DRUG BENEFITS Not subject to deductible and co-insurance (Mandatory Generic Substitution)	**YOUR SHARE OF ELIGIBLE EXPENSE**	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$7.50	Not Covered
Brand Name Formulary Drugs	$35.00	Not Covered
Non-Formulary Brand Name Drugs	$50.00	Not Covered
Mail Order 90-Day Supply (Mandatory after 2 refills at retail)		
Generic Drugs	$15.00	Not Covered
Brand Name Formulary Drugs	$70.00	Not Covered
Non-Formulary Brand Name Drugs	$100.00	Not Covered